



Patient Registration Form

www.cfhc.care

Castle Family Health Centers, Inc. is required to collect demographic information regarding the patients we serve. The information you provide is confidential. Please check Not Reported/Refused if you do not wish to answer a specific question. Thank you for choosing Castle Family Health Centers as your health care provider.

Section 1: Patient Information

First Name: _____ Middle Name: _____ Last Name: _____

Suffix: Sr. Jr. II III Other: _____ Social Security #: _____ - _____ - _____ Sex: Male Female

Date of Birth: ____/____/____ Marital Status: Single Married Divorced Widowed Other: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Email: _____ @ gmail.com att.net yahoo.com Comcast.net aol.com _____

Primary Phone: Home Cell Work / Home #: () _____ - _____ Cell: () _____ - _____

Work #: () _____ - _____ Primary Language: English Spanish Sign Language Other: _____

Race: American Indian or Alaska Native Asian African American Caucasian Native Hawaiian or

Other Pacific Islander Other: _____ **Primary Doctor:** _____

Ethnicity: Latino/Hispanic Non-Latino/Hispanic Not Reported/Refused

Gender Identity: Not Reported/Refused Female Male Transgender Female (Male-to-Female)

Transgender Male (Female-to-Male) Non-Binary (Identifying as any gender other than female or male)

Uncertain Other: _____

Sexual Orientation: Not Reported/Refused Heterosexual/Straight Homosexual/Gay/Lesbian Bisexual

Uncertain Other: _____

Section 2: Guarantor (Financial Responsible Individual) Information

Guarantor is: Patient is Guarantor (no need to complete the rest of this section) Person Company

Patient's Relation to Guarantor: Child Parent Spouse Employer Other: _____

First Name: _____ Middle Name: _____ Last Name: _____

Suffix: Sr. Jr. II III Other: _____ Social Security #: _____ - _____ - _____ Sex: Male Female

Date of Birth: ____/____/____ Marital Status: Single Married Divorced Widowed Other: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ - _____ Cell Phone: () _____ - _____ Work Phone: () _____ - _____

Primary Language: English Spanish Sign Language Other: _____

How did you learn about CFHC? Family/Friend Physician Referral Online Newspaper

Section 3: Family Income and Shelter Information

We request income on all patients for governmental reporting purposes. If eligible for the Sliding Fee Scale, please complete separate Sliding Fee Application.

Income Period: Weekly Bi-weekly Monthly Bi-Monthly Quarterly Annually Other: _____

Gross Income for Period: \$_____ Number of Individuals Income Supports: _____ Disabled: Yes No

Homeless Status: Not Homeless Homeless Shelter Transitional Doubling Up Street Other _____

Worker Status: Migrant Not Migrant Seasonal Veteran: Yes No

Section 4: Patient Insurance Information

Insurance Coverage: Private Insurance Central California Alliance for Health Medi-cal Medicare None

Primary Insurance Company: _____ Member ID # _____ Group# _____

Primary Subscriber Information:

Last Name: _____ First Name: _____ Date of Birth: _____

Patient Relationship to Subscriber: Parent Child Spouse Other: _____

Address (if different than patient) _____ City: _____ State: _____ Zip: _____

Secondary Insurance Company: _____ Member ID # _____ Group# _____

Secondary Subscriber Name: _____ Date of Birth: _____

Section 5: Emergency Contact Information

Patient Relationship to Contact: Parent Child Spouse Other: _____

Last Name: _____ First Name: _____ Date of Birth: _____

Address (if different than patient) _____ City: _____ St: _____

Zip: _____ Home Phone: _____ Cell Phone: _____ Work: _____

Financial Agreement Assignment of Benefits & Authorization for Treatment:

I hereby certify that the above information is true, I authorize any medical treatment, anesthetics or surgical procedures, as the attending physician deems necessary. I hereby authorize my providers to release medical information as required and permitted by law. I understand that I am responsible for payment if charges incurred in the course of treatment. Should this account become delinquent and be referred to any attorney or collection agency, the undersigned will pay actual attorney's fees and collection expenses. A \$25.00 fee is charged on all return checks. In addition to cash or check, Visa and MasterCard are accepted.

Patient/Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____